Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DON F JOHNSON MD
P O BOX 741865
DALLAS TX 75374

Carrier's Austin Representative Box
Box Number 19

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Date Received
January 18, 2012

MFDR Tracking Number
M4-12-1661-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAM…CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS…THE CURRENT RULES ALLOW REIMBURSEMENT…AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider should have billed an additional line to report the MI service. The system priced bill is correct per the modifiers billed by provider. Per State Website, appending with modifier MI will only allow $50.00 which is how the bill was processed, under the 'Tiered reimbursement method for more than one-non MMI/IR examinations under the same order' section."

Response Submitted by: Pappas & Suchma, PC, P. O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2011	99456-W5-NM-MI	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. 28 Texas Administrative Code §130.6 sets out procedures for Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings

4. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated July 19, 2011
   - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated December 13, 2011
   - No denial reason code(s) listed on submitted EOB

Issues

1. Has the Requestor billed with correct modifiers for these types of services?
2. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $700.00 for CPT code 99456- W5-NM-MI representing multiple impairment ratings. As multiple impairments were rendered, the appropriate billing should have reflected CPT code 99456-W5-NM and CPT code 99456-W5-MI.

   28 Texas Administrative Code §134.204 (j)(4)(B) which states:

   "When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code."

   28 Texas Administrative Code §134.204 (j)(2)(A) states:

   "If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier 'NM shall be added."

2. Review of the submitted documentation supports the examinations, yet any reimbursement methodology allowance per 28 Texas Administrative Code §134.204 for individual services was contingent upon the use of the modifiers explained in the entire rule. The medical bills submitted by the requestor for review does contain CPT codes that do not reflect that the appropriate modifiers were applied according to the rule, therefore, reimbursement is disallowed.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 25, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC

Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.